

# Hatch 1

## 1Q/2006 Plant Inspection Findings

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### Initiating Events

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### Mitigating Systems

**Significance:** **G** Mar 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Demonstrate that the Traveling Water Screen System Was Effectively Controlled per 10 CFR 50.65 (a)(2)**

An NRC-identified Non-Cited Violation (NCV) of 10 CFR 50.65 (Maintenance Rule) was identified for failing to demonstrate that the performance of the Traveling Water Screens (TWS) was being effectively controlled through the performance of appropriate preventive maintenance such that the system remained capable performing its intended function to provide adequate water quality to the safety-related Residual Heat Removal Service Water (RHRSW) pumps. As a result, after the Maintenance Rule (a)(2) performance criteria was exceeded, the licensee had neither established goals nor monitored the performance of the TWS per 10 CFR 50.65 (a)(1). The licensee entered their failure to monitor the performance of the TWS into their Corrective Action Program for resolution.

This finding was more than minor because it adversely affected the equipment performance attribute associated with the Mitigating Systems cornerstone objective in that debris were able to bypass the TWS which degraded RHRSW pump flow. This finding was of very low safety significance because redundant RHRSW pumps were operable and the affected RHRSW pumps were returned to operable status within the Technical Specification allowed outage times. This finding directly involved the cross-cutting aspect of Problem Identification and Resolution, in that, the licensee failed to identify that each of the RHRSW pump degraded flow events were maintenance preventable functional failures of the TWS.

Inspection Report# : [2006002\(pdf\)](#)

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### Barrier Integrity

**Significance:** **G** Jul 29, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Adequately Implement Design Control Measures**

A non-cited violation of 10 CFR 50, Appendix B, Criterion III, involving the failure to adequately control the configuration of the drywell to torus vacuum breaker actuators was identified. This resulted in the failure to maintain containment integrity requirements because one of two required barriers for containment integrity was inappropriately removed during a design change of the actuators.

This finding is more than minor because it affected the configuration control attribute of the Barrier Integrity cornerstone to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. This finding was determined to be of very low safety significance (Green) because for each of the affected torus vacuum breaker actuators, the outboard containment isolation valve in the associated penetration remained functional. This finding affects the human performance crosscutting area in that licensee staff failed to adequately implement the site process for design controls.

Inspection Report# : [2005006\(pdf\)](#)

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### Emergency Preparedness

**Significance:** **W** Jun 30, 2005

Identified By: NRC

Item Type: VIO Violation

#### **Failure to Maintain Facilities and Equipment to Support Emergency Response**

The NRC identified an apparent violation associated with emergency preparedness planning standard 10 CFR 50.47(b)(8). [The Technical Support Center (TSC) was rendered inoperable for greater than seven days due to planned modification activities.]

This finding is greater than minor because it is associated with the Facilities and Equipment attribute of the Emergency Preparedness (EP) Cornerstone and impacts the objective of the Hatch TSC to maintain facilities and equipment to support emergency response in that the TSC was inoperable during the modification activities and could not be returned to operable within a short period. Based upon IMC 0609, Appendix B, Emergency Preparedness Significance Determination Process, Sheet 1, and the examples provided in Section 4.8, this finding was [preliminarily] determined to be of low to moderate safety significance (White) because the PS function was lost in that the TSC was inoperable for greater than seven days due to a planned outage in which activities were not scheduled to proceed with high priority for completion. Inspection Report# : [2005009\(pdf\)](#)

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Physical Protection

[Physical Protection](#) information not publicly available.

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## Miscellaneous

**Significance:** N/A Jul 29, 2005

Identified By: NRC

Item Type: FIN Finding

### **Biennial Identification and Resolution of Problems Inspection Assessment**

The inspectors identified that the licensee was generally effective at identifying problems and entering them into the corrective action program (CAP) for resolution. The licensee maintained a low threshold for identifying problems as evidenced by the continued large number of condition reports (CR) entered annually into the CAP. The inspectors also determined that the licensee was generally prioritizing and evaluating issues properly. The inspectors identified minor problems involving corrective actions for operating experience not being documented within the corrective action program, timeliness of evaluations, and corrective actions which were incomplete. Non-cited violations (NCVs) related to the effectiveness of corrective actions and inadequate evaluation of issues were identified. Audits and self-assessments continued to identify issues related to the corrective action program. On the basis of interviews conducted during the inspection, the inspectors identified that personnel at the site felt free to raise safety concerns to management and to resolve issues via the CAP.

Inspection Report# : [2005006\(pdf\)](#)

Last modified : May 25, 2006